A Year in Review

The Colorado Multi-Stakeholder Patient-Centered Medical Home Pilot

PCPCC CMD Meeting

June, 1, 2010
Multi-Payer Pilot Stakeholders

**Health Plans**
- Aetna
- Anthem-Wellpoint
- CIGNA
- Colorado Medicaid (HCPF)
- CoverColorado
- Humana
- United Healthcare

**Employers**
- Colorado Business Group on Health
- Centura
- IBM
- McKesson
- State of Colorado
- Patient Centered Primary Care Collaborative (PCPCC)

**Physician Societies**
- AAFP/CAFP
- American College of Physicians
- Colorado Medical Society

**Others**
- Colorado Health Department (CDPHE)
- University of Colorado-Denver
- Consumers

**Hospitals**
- HealthONE
- Centura
- Exempla
- Memorial Hospital
- Colorado Hospital Association
- Others

**Associated IPAs**
- Integrated Physician Network
- Northern Colorado IPA
- Physician Health Partners
  - Primary Physician Partners
  - South Metro Physicians
- MedSouth

**Pilot Partner Region**
- Health Improvement Collaborative of Greater Cincinnati

**Pilot Evaluator**
- Harvard School of Public Health

**Funders**
- The Colorado Trust
- The Commonwealth Fund
The Front Line Innovators!

- Belmar Family Medicine
- Broomfield Family Practice
- Clinix Health Services of CO
- DeYoung Family Medicine
- Family Care Southwest
- Family Practice Associates
- Ideal Family Healthcare
- Internal Medicine Clinic of Ft. Collins

- Lakewood Family Medicine
- Lone Tree Family Practice
- Michael Mignoli MD
- Miramont Family Medicine
- Mountaintop Family Health
- Provident Adult & Senior Medicine
- Southpark Internal Medicine
- Westminster Medical Clinic
Pilot Parameters

• Two-to-three-year pilot
  • Convened January 2008; TA December 2008; Started May 2009
• PCMH Joint Principles
• NCQA PCMH Recognition
  • 14 at Level III; 2 at Level II
• 17 Family & Internal Medicine Practice sites
  • Various sizes across the Front Range
• 20,000 patients covered (100,000 affected)
• Three-tiered payment structure
  • Fee for service (FFS); Care management fee (PMPM); P4P
The Colorado Multi-Payer Committee Organization Chart

Phase II – Operationalization & Implementation
12/5/2008-Current

- Physician Advisory Committee
  - Pilot Practice Physicians
  - Support Staff
  - National Physician Societies
  - Physicians from Physician Societies
  - Convening Organization Staff

- Health Plan Sub-Group
  - Health Plan Staff
  - Physician Society Support Staff
  - Convening Organization

- Patient Advisory Committee
  - Patients from Pilot Practices
  - Consumer Advocacy Groups
  - Convening Organization Staff

- Hospital Sub-Group
  - Hospital Staff
  - Pilot Practice Physicians
  - Health Plan Staff
  - Hospital Association Staff
  - Convening Organization Staff

- Mental/Behavioral Health Integration Sub-Group
  - Mental/Behavioral Healthcare Experts
  - Pilot Practice Physicians
  - Convening Organization Staff

PCMH Steering Committee
Colorado Multi-Stakeholder, Multi-State Patient Centered Medical Home Pilot Convening Organization Timeline

- First meeting, held in person, to determine pilot parameters, stakeholder involvement, budget requirements, practice selection criteria, reimbursement model etc...
- Steering Committee Established, includes representation from health plans, physicians, physician societies, and others. Meetings held bi-monthly with 2 additional in person meetings.
- Physician and Health Plan sub-groups formed to work on the operationalization issues.
- Selected pilot practices based on location, quality improvement history, culture, technology and participating insurer penetration.
- PMPM range determined by physician advisory committee and health plan sub-group through research and estimated cost to practices to add the additional scope of work transform into a PCMH.
- Announced the pilot to the healthcare community in the Denver metro and across the state of Colorado.
- ASO participation deemed vital to the success of the pilot to improve payment penetration in each practice.

- Pilot measures determined based on national measures.
- Reception held for practices and health plans to celebrate the launch of the pilot.
- Official launch of the pilot.
- Patient sub-group created to ensure the patient voice is considered and involved in the process, including creating patient education materials.
- Hospital sub-group created to work on improving bi-directional communication between PCPs and hospitals.
- Mental health integration sub-group created to focus on the integration of mental and behavior health into the pilot practices.
- P4P Specifications finalized through the work of the health plans and physician advisory group.
- Actionable data provided to pilot practices from health plans.
- Uniform patient satisfaction surveys implemented.
Patient-Centered Planned Care

Before the Visit
- Prepared Care Team
  - labs
  - screenings
  - specialist reports

Medical Neighborhood
- specialists
- mental health
- hospitals
- community resources
- social work
- home health
- peer programs
- others

Access
- by visit
- by e-mail
- by phone

During the Visit
- Front Office
  - build relationships
  - explore needs and preferences
- Nurse/MA
  - standing orders
  - flow sheets
- Provider (MD/PA/NP)
  - set shared agenda for visit
  - review chronic, preventive, acute care issues
  - collaborate to set SM goals
  - create care plan using shared decision making
  - review patient experience

Care Coordination

After the Visit
- Population Management
  - registry/reporting
  - outreach
  - prioritize population
- Follow-Up
  - test and referral tracking
  - revise plan as needed
  - problem solve
- Gather Patient Experiences
  - symptom monitoring
  - medication assessment
  - self-efficacy

CARE PLAN

Self-Management Support

Improved Outcomes
- Increased Healthy Behaviors
- Improved Quality, Safety, and Clinical Outcomes
- Increased Collaboration between Patient, Care Team, and Medical Neighborhood
- Improved Physician and Staff Satisfaction and Retention
- Reduced Cost Trends

www.NewHealthPartnerships.org
Prioritizing Care Plan Management and Care Coordination

TIME/COST

Low Risk Patients

High Risk Patients

Single Chronic Condition and Complex Patients

Multiple Chronic Conditions and Complex Patients

PREVENTION

Goals/Measures

• Improve quality
  • Diabetes
  • Cardiovascular disease
  • Tobacco
  • Depression
  • Prevention

• Reduce cost trends
  • Emergency room (ER) visits
  • Hospital admissions
  • Generic pharmacy

• Improve satisfaction
  • Patients/families
  • Health care team

• Internal
• External
  • Matched comparison design
  • Meredith Rosenthal
    • Harvard
# P4P Measures

<table>
<thead>
<tr>
<th>P4P Clinical Measures</th>
<th>P4P Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HgA1c&gt;9 (DM)</td>
<td>15%</td>
</tr>
<tr>
<td>2. BP &lt;130/80 (DM)</td>
<td>25%</td>
</tr>
<tr>
<td>3. LDL &lt;100 (DM)</td>
<td>36%</td>
</tr>
<tr>
<td>4. Tobacco Counseling (DM)</td>
<td>80%</td>
</tr>
<tr>
<td>5. Depression Screening (DM)</td>
<td>40%</td>
</tr>
<tr>
<td>6. LDL &lt;100 (CV)</td>
<td>50%</td>
</tr>
<tr>
<td>7. BP &lt;140/90 (CV)</td>
<td>75%</td>
</tr>
<tr>
<td>8. Tobacco Counseling (CV)</td>
<td>80%</td>
</tr>
<tr>
<td>9. Depression Screening (CV)</td>
<td>40%</td>
</tr>
</tbody>
</table>

## Cost Trend Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce ER Visits</td>
<td>5%</td>
</tr>
<tr>
<td>Reduce IP Hospitalizations</td>
<td>5%</td>
</tr>
<tr>
<td>Increase Generic Pharmacy</td>
<td>10%</td>
</tr>
</tbody>
</table>
Data Slides

Pilot Average DM Measures

Number of Practices Reporting
June 2009 - 9
Sept 2009 - 11
March 2010 - 15

Number of Practices Reporting
June 2009 - 9
Sept 2009 - 11
March 2010 - 15
Pilot Average Heart /Stroke Measures

Number of Practices Reporting
- June 2009 - 3
- Sept 2009 - 7
- March 2010 - 14

- BP <140/90 mm Hg
- Lipid profile
- LDL < 100 mg/dL
- Use of aspirin
- Queried about tobacco use
- Tobacco cessation intervention
- Prescribed lipid lowering therapy

June 2009: 3
Sept 2009: 7
March 2010: 14
STRONGER Patient & Provider Relationships

Mountaintop Family Health

Pat Schmidlapp
Colorado Multi-State Multi-Stakeholder Technical Assistance Timeline

Phase 1a (May 2009 – Aug 2009)
- Review and Use Quality Improvement Tools and Models
  - Use of Technology
    - Registry
    - Patient Centered Care/Communication/Engagement
    - Patient Self Efficacy and Individualized Assessment
    - Patient Self-Management Support
  - Decision Support/Team Based Care/Patient Tracking
    - Evidence Based Guidelines
      - Diabetess, Heart/Stroke, Depression Screening
    - Team based Care
  - Access and Scheduling
    - Implement various ways to increase access
  - Organization of Practice
    - Leadership Team-building

Phase 1b (Aug 2009 – Nov 2009)
- Patient Centered Care/Communication/Engagement
  - Patient Satisfaction/Experience
  - Decision Support/Team Based Care/Patient Tracking
  - Evidence Based Guidelines
    - Diabetes, Heart/Stroke, Depression Screening
  - Care Management
    - Establish Medical Neighborhood
  - Access and Scheduling
    - Implement various ways to increase access

Phase 1c (Dec 2009 – June 2010)
- Use of Technology
  - E-Prescribing
  - Decision Support/Team Based Care/Patient Tracking
    - Evidence Based Guidelines
      - Back Pain, Prevention, Depression - Acute and the rest of Heart/Stroke measures
  - Shared Decision Making
  - Test and Referral Tracking
  - Care Management
    - Coordination of Care/Transition of Care with Medical Neighborhood
    - Community Resources
  - Access and Scheduling
    - Implement various ways to increase access
  - Organization of Practice
    - Human Resources
    - Finance

Phase 2 (July 2010 –)
- Maintain Phase 1 and Phase 2
- Evidence Based Guidelines
  - Prevention, Depression - Continuation, other optional measures

Ongoing Pilot Events and Reports
- Regular team meetings (at least 2 per month)
- Learning Sessions 1, 2, and 3
- Monthly practice calls on the 1st and 3rd Fridays of each month
- Monthly reporting of clinical measures
- Monthly reporting of summary report
Technical Assistance

1. Office Redesign
Based on IPIP - Planned Care Model - IHI
Focused Approach Related to NCQA Tool
In Office QI Coaches
Learning Collaboratives & Calls
Monthly Practice Reporting

2. Technology
Care Plan - Registry
Common Communication Platform
HIPAA Compliant E-Mail
Patient Portal - Engagement

3. Integrating Care
Expand Services; Coordinate/Integrate care with “Medical Neighborhood” using Compacts
Co-Located/Shared/Referred Services
Care Plan Manager/Coordinator

4. Patient Centered
Enhance Access
Form Partnership with Patients - Shared Decision Making
Patient Activation & Satisfaction (Experience)
Quality Improvement

- **Practice Structure**
  - Care Coordinators - 94%
  - Registry for Diabetes and Heart/Stroke – 100%
  - Compacts – 18%
- Expanding Team Roles

Cost
- Reducing ER – 4 practices doing mini pilots
- Admissions,
- Generic Pharm - E-prescribing 100%

Patient Satisfaction

- **Access - Expanded hours and email communication**
  - Extended Hours – 75%
  - E-Mail – 87%
  - Website 100%
- Patient Education and Engagement – 100%

Provider and Staff Satisfaction
IMPROVED Communication: Hospitals & PCPs
### Sky Ridge Medical Center PCMH Sub-Committees

<table>
<thead>
<tr>
<th>Emergency Department</th>
<th>HIM</th>
</tr>
</thead>
<tbody>
<tr>
<td>~Educate ED staff regarding PCMH</td>
<td>~Develop timely notification to PCPs</td>
</tr>
<tr>
<td>~Identify patients who belong to</td>
<td>~when patients are in the ED</td>
</tr>
<tr>
<td>PCMH</td>
<td>~Ensure all results are faxed to PCPs</td>
</tr>
<tr>
<td>~Collaborate with PCPs and exchange</td>
<td>~Review information being sent to</td>
</tr>
<tr>
<td>information freely</td>
<td>PCPs for quality</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Future Programs and Marketing</td>
<td>Physician Relations</td>
</tr>
<tr>
<td>~Market services provided by SRMC</td>
<td>~Identify and work with PCPs who</td>
</tr>
<tr>
<td>~Advertise PCMH pilot participation</td>
<td>have joined the PCMH model</td>
</tr>
<tr>
<td>~Serve as Medical Neighborhood for</td>
<td>~Educate PCPs in the community</td>
</tr>
<tr>
<td>our community</td>
<td>about our services and support for pilot</td>
</tr>
<tr>
<td></td>
<td>~Evaluate progress</td>
</tr>
</tbody>
</table>

**Note:**
The content is from Sky Ridge Medical Center's PCMH sub-committees, focusing on different areas such as Emergency Department, HIM, Future Programs and Marketing, and Physician Relations, each with specific tasks and responsibilities.
Better Care Coordination – Medical Neighborhood

Jan Vergo, RN
Westminster Medical Clinic
**INCREASED Patient Activation**

Creation of Patient Advisory Committee

- Developed *with input from the Physician Advisory Committee* patient education materials
- Provided feedback on the development of the patient survey and other patient communications
- Working with their practices to boost the role of the patient in the practice
How the Medical Home Drives Value: What We Are Operationally Doing Different

Expanded Patient-Centric Clinical Services and Capabilities

**Benefits**

- More time for patients
- Better care continuity
- Improved care transitions
- Improved quality of reporting
- More efficient care delivery
- Enhanced patient focus
- Improved patient safety
- Improved practice profitability and satisfaction
- Simplified and coordinated health care experience

**Enhanced Access**
- Timely appointment scheduling
- Evening, weekend and holiday hours
- After-hours support

**Care Coordination and Chronic Condition Management**
- Weekly identification of patients in transition or at risk
- Specialty referral coordination and tracking
- Disease and case management enrollment

**Team Care**
- Physician-directed team both in and outside of the practice setting
- Management of care transitions across the health care continuum

**Performance Measurement, Assessment and Improvement**
- Practice in accordance with clinical evidence
- Performance evaluation based on medical best practices
- Measurement of clinical processes and outcomes

**Clinical Information Systems**
- Care management
- Decision support
- Electronic prescription filling

**Enabling Technology and Practice Support**

**Technology and Tools**
- Personal Health Record
- Point of care information
- Electronic prescriptions
- In-depth reporting

**Care Coordination**
- Health plan care and disease management
- Educational materials
- Patient activation tools

**Transformation Support**
- Assigned facilitator
- Online tools
- “Boots on the ground” resources

**PRACTICE QUALIFICATIONS (Based on NCQA PCC-PCMH Standards)**

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Questions?

Thank You!

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